Bates County Memorial Hospital

BCMH Family Care Clinics

ADRIAN CLINIC
HIGH STREET CLINIC
NURSERY STREET CLINIC
RICH HILL CLINIC

Financial Clearance Department

615 W. Nursery
PO Box 370
Butler, MO 64730
Phone: 660-200-7314
Fax: (660)200-7021

Bates County Memorial Hospital (BCMH) provides financial assistance for medically necessary services provided in the hospital setting, surgical clinic and outpatient specialty clinics only to residents of Bates County. The Family Care Clinics as rural health clinics, have no geographical restrictions.

BCMH uses the current federal poverty guidelines and family size as a basis for determining the eligibility for financial assistance. **A $20.00 Co-pay is due at time of service at these locations only: Emergency Room, Outpatient Specialty Clinic, FCC Adrian, FCC Nursery Street, FCC High Street, FCC RICH HILL and BCMH Surgical Clinic.**

List of Documents needed to process application: (Any documents altered will not be accepted)

1.) Payroll check stubs- copies of last three months.

   a. If you do not receive check stubs, please submit the past three months of bank statements.
   b. If you do not receive check stubs, please submit a written notice signed and dated from your employer with earnings information.

2.) Copies of any of the following that apply:
   a. Social Security Income, Disability Income, Unemployment Income, or other income such as dividends, interest, rental income, child support, etc.

3.) Food Stamp letter showing benefits received (if applicable).

4.) Written Statement from applicant describing current financial/employment situation *required*

5.) Last year's tax returns ***may be asked for*** *you to provide at a later date* .

6.) Bankstatements- copies of last three months

We Must Receive All Requested Documents In Order To Complete Your Application

Once all documentation is received, applications are processed within 30 days. Once your application is processed you will receive a determination letter in the mail. If approved, your assistance will be applied to any current outstanding balances. This approval will be valid for 6 months from the date you signed the application. If you are denied you may reapply at any time.

We will do our very best to apply the financial assistance to your accounts, if you receive a statement or phone call in regards to services that you feel should have been covered please contact us as soon as possible.

As a courtesy Alliance Radiology and Electric City Emergency Physicians honors the BCMH financial assistance. You may need to fax or mail them a copy of your approval letter along with their statement.

If you have questions, please contact us at 660-200-7314

Sincerely,

Patient Accounts Counselor of BCMH

updated 7/2017

Bates County Memorial Hospital

BATES COUNTY MEMORIAL HOSPITAL AND FAMILY CARE CLINICS

Rich Hill Clinic, Adrian Clinic, Nursery St. Clinic, High St. Clinic

FINANCIAL ASSISTANCE APPLICATION

Renewal ____Yes ____No
Valid _____to_____
(Office Use Only)

Non Bates County Resident Family Care Clinics Only_____

HEAD OF HOUSEHOLD

Last Name	First Name	Middle I.	DOB	Age	Telephone No.	County of Residence

Street Address	Apt No.	City	State	Zip Code	Marital Status	# of Dependents

Employer Name	Employer Address, City, State & Zip Code

How long employed?	Employer Telephone No.	Position Title	Social Security No. (Optional)

SPOUSE/PARTNER

Last Name	First Name	Middle I.	DOB	Age	Social Security No. (Optional)

Employer Name	Employer Address, City, State, & Zip Code

How long employed?	Employer Telephone No.	Position Title	

TAX DEPENDENTS

Last Name	First Name	DOB	Age	Relationship to Head of Household	Social Security No.

INCOME-- OFFICE USE ONLY

GROSS INCOME	HOURLY	MONTHLY	QUARTERLY	YEARLY
Primary Wages				
Secondary Wages or other income				
Social Security Income				
Pension				
Disability				
Food Stamps				
Rental Income				
Alimony / Child Support				
Unemployment				
State Assistance				
Other (total household income required)				
TOTAL				

I herby certify that I have not knowingly withheld any information contained on this application and that all information disclosed is correct to the best of my knowledge.

I give permission for my information to be verified with the IRS or other resources to approve my application.

X **X**

Patient / Responsible Party Signature	Date	Spouse/Partner Signature	Date

Bates County Memorial Hospital Representative	Date	Department	Nov-15